SECTION 2

UTAH HOME AND COMMUNITY - BASED WAIVER SERVICES FOR INDIVIDUALS WITH PHYSICAL DISABILITIES PROVIDER MANUAL

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1 GENERAL POLICY

Under Section 1915(c) of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to "waive" certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. Since July 1, 1998 the State of Utah has provided Medicaid-reimbursed home and community-based waiver services for individuals with physical disabilities. The approval includes waivers of:

* the "comparability" requirements in subsection 1902(a)(10)(B) of the Social Security Act, and

* the institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act.

Waiver of Comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to only a limited number of eligible individuals who meet the State's criteria for Medicaid reimbursement in a nursing facility (NF). "Waiver services" need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a "cost-effective" or a "cost-neutral" alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements the State uses more liberal eligibility income and resource calculations when determining recipients' Medicaid eligibility.

1 - 1 Acronyms and Definitions

For purposes of the Home and Community-Based Waiver for Individuals with Physical Disabilities (Physical Disabilities Waiver), the following acronyms and definitions apply:

Physical Disabilities Waiver Medicaid 1915c HCBS Waiver for Individuals with Physical Disabilities

CMS Centers for Medicare and Medicaid Services

DSPD Division of Services for People with Disabilities

DHCF Division of Health Care Financing

HCBS Home and Community-Based Services

MAR Maximum Allowable Rate

NF Nursing facility

1 - 2 CMS Approved Waiver Implementation Plan

A. The State Implementation Plan for the Physical Disabilities Waiver approved by CMS serves as the State's authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.

B. This manual does not contain the full scope of the Waiver Implementation Plan. To understand the full scope and requirements of the Physical Disabilities Waiver program, the State Implementation Plan should be referenced.

C. In the event provisions of this manual are found to be in conflict with the State Implementation Plan, the State Implementation Plan will take precedent.

2 SERVICE AVAILABILITY

Home and community-based waiver services are covered benefits only when provided:

1. To an individual with disabilities who has established eligibility for state matching funds through the Utah Department of Human Services in accordance with UCA 62A-5;

2. To an individual determined to meet the eligibility criteria defined in the CMS approved Waiver Implementation Plan;

3. Pursuant to a written individual service plan.

2 - 1 Eligibility for Waiver Program

A. Home and community-based waiver services are covered benefits only for a limited number of Medicaid eligibles for whom there is a reasonable indication that they might need the services provided in a Medicaid-certified NF in the near future unless they receive home and community-based services, and for whom, but for the provision of such services, would receive the NF services, the cost of which would be reimbursed under the Medicaid State Plan.

B. In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility, or the equivalent care provided through the Physical Disabilities Waiver, the individual responsible for assessing level-of-care shall document that at least two of the following factors exist:

1. Due to diagnosed medical conditions, the individual requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

2. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through the Physical Disabilities Waiver; or

3. The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of the Physical Disabilities Waiver.

C. The individual responsible for the assessment will also document that the applicant meets the following additional targeting criteria:

1. 18 years of age or older.

2. Has at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual.

3. Is medically stable, has a physical disability and require in accordance with her/his physician's written documentation, at least 14 hours per week of personal assistance services (as described in Appendix B of this waiver) in order to remain in the community and prevent unwanted institutionalization. For purposes of this waiver, the individual's qualifying disability and need for personal assistance services are attested to by a medically determinable physical impairment which the physician expects will last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs, to the extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living / instrumental activities of daily living.

4. Is capable, as certified by his/her physician, of selecting, training and supervising his/her personal attendant(s).

5. Is capable of managing his/her own financial and legal affairs.

D. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be maintained through the Physical Disabilities Waiver program.

E. Inpatients of hospitals, nursing facilities, or ICFs/MR are not eligible to receive waiver services (except as specifically permitted for support coordination discharge planning in the 90-day period before their discharge to the Physical Disabilities Waiver).

2 - 2 Applicant Freedom of Choice of NF or Physical Disabilities Waiver

A. Medicaid recipients who meet the eligibility requirements of the Physical Disabilities Waiver may choose to receive services in a NF or through the Physical Disabilities Waiver if available capacity exists, to address health, welfare, and safety needs.

B. If no available capacity exists in the Physical Disabilities Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the Physical Disabilities Waiver.

C. If available capacity exists in the Physical Disabilities Waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by a Physical Disabilities Waiver representative. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the Physical Disabilities Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

D. Once the applicant has chosen to enroll in the Physical Disabilities Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time a substantial change in the individual's condition results in a change in the written individual support plan. It is, however, a Physical Disabilities Waiver participant's option to choose institutional (NF) care at any time and voluntarily disenroll from the Physical Disabilities Waiver.

2 - 3 Physical Disabilities Waiver Participant Freedom of Choice

A. Upon completion of the comprehensive assessment instrument, the individual in participation with the waiver support coordinator will participate in the development of the individual service plan to address the individual's identified needs.

B. The individual will be given choice of services to meet an identified need if more than one cost-effective option exists.

C. The individual will be given a choice of available qualified providers of waiver services identified in the individual support plan.

D. The waiver support coordinator will review the contents of the written individual support plan with the individual prior to implementation. The written individual support plan will constitute formal notice of the agency's decision regarding authorized services to be provided to the individual and will include notice of the individual's right to appeal the decision to the State Medicaid Agency. The individual must acknowledge receipt of the notice of decision and right to a fair hearing by signing the individual support plan.

E. Subsequent revision of the individual's individual support plan as a result of annual re-assessment or significant change in the individual's health, welfare, or safety requires proper notice to the individual as described in item E above, plus notice that the individual has the right to select to receive services in a Medicaid NF in lieu of continued participation in the waiver.

1. A significant change is defined as a major change in the recipient's status that:

   - is not self-limiting;

   - impacts on more than one area of the recipient's health status; and

   - requires interdisciplinary review and/or revision of the individual support plan.

   NOTE A condition is defined as self-limiting when the condition will normally resolve itself without intervention by waiver personnel. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment using the MDS-HC assessment instrument.

2. A reassessment is required if significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.

2 - 4 Termination of Home and Community-Based Waiver Services

The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

A. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the waiver support coordination agencies within 30 days from date of disenrollment. Documentation will be maintained by the waiver support coordination agencies detailing the discharge planning activities completed with the waiver participant as part of the disenrollment process.

B. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

1. Participant death;

2. Participant no longer meets financial requirement for Medicaid program eligibility;

3. Participant has moved out of the State of Utah; or

4. Participant whereabouts are unknown.

C. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the waiver support coordination agencies within 30 days from dates of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the local support coordination agencies detailing the discharge planning activities completed with the waiver participants as part of the disenrollment process.

D. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver participant no longer meets the corresponding institutional level of care requirements, the participant's health and safety needs cannot be met by the current program's services and supports, or the participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate an individual support plan that meets minimal safety standards.

E. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

1. Appropriate movement amongst programs;

2. Effective utilization of program potential;

3. Effective discharge and transition planning;

4. Provision of information, affording participants the opportunity to exercise all rights; and

5. Program quality assurance/quality improvement measures.

F. The special circumstance disenrollment review process will consist of the following activities:

1. The waiver support coordinator recommending disenrollment will compile information to articulate the disenrollment rationale.

2. The waiver support coordinator will then submit the information to the state-level program management staff for their review of the documentation of support coordination activities and of the disenrollment recommendation.

3. If state-level program management staff concur with the support coordination recommendation, the case will be forwarded to the DHCF for a final decision.

4. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

5. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

6. The DHCF final disenrollment decision will be communicated to both the support coordinator and the state-level program management staff in writing.

G. If the disenrollment is approved, the waiver support coordinator will provide to the individual the required written notification of agency action and right to fair hearing information.

H. The support coordinator will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

2 - 5 Fair Hearings

A. The Division of Health Care Financing provides an individual applying for or receiving waiver services an opportunity for a hearing upon written request, if the individual is:

1. Not given the choice of institutional (NF) care or HCBS waiver services;

2. Denied the waiver provider(s) of choice if more than one provider is available to render the service(s);

3. Denied access to waiver services identified as necessary to prevent institutionalization; or

4. Experiencing a reduction, suspension, or termination of waiver services identified as necessary to prevent institutionalization.

B. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from the waiver support coordinator if the individual is denied a choice of institutional or Physical Disabilities Waiver program, found ineligible for the waiver program, denied access to the provider of choice for a covered waiver service, or experiences a reduction, suspension, or termination of waiver services. The Notice of Agency Action delineates the individual's right to appeal the decision.

C. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Health Care Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.

D. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

E. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Health Care Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

A. Home and community-based waiver services for recipients with physical disabilities are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency to provide the services as part of the Physical Disabilities Waiver. In addition to a Medicaid provider agreement, all providers of waiver services must also have a current contract with DHS/DSPD.

B. Any willing provider that meets the qualifications defined in the Physical Disabilities Waiver Implementation Plan, Appendix B-2, Provider Qualifications, may enroll at any time to provide a Physical Disabilities Waiver service by contacting DSPD. DSPD will facilitate completion and submission of the required Medicaid provider application and completion of the required local contract. The provider is only authorized to provide the waiver services specified in Attachment A of the Medicaid provider agreement submitted by the provider.

3 - 2 Provider Reimbursement

A. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the negotiated contract with DSPD.

B. Providers may only claim Medicaid reimbursement for services that are authorized by the responsible waiver support coordinator. Claims must be consistent with the amount and frequency authorized by the waiver support coordinator.

3 - 3 Standards of Service

Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, the terms and conditions of the Waiver Implementation Plan, and the terms and conditions contained in the DSPD contract.

3 - 4 Provider Rights to a Fair Hearing

The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health, Division of Health Care Financing, or its administrative contractor for the Physical Disabilities Waiver, and who submit a written request for a hearing to the agency. Please refer to Utah Department of Health Administrative Hearing Procedures for Medicaid/UMAP Recipients, Applicants, and Providers in Section 1, Chapter 6 - 14, Administrative Review/Fair Hearing. This includes actions of DSPD or a waiver support coordinator relating to enrollment as a waiver provider, free choice of available providers by waiver participants, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegated waiver responsibilities.

4 SUPPORT COORDINATION

4 - 1 Support Coordinator Qualifications

Support coordination in the Physical Disabilities waiver is an administrative case management function rather than a covered waiver service and is performed by employees of the DSPD. Qualified support coordinators shall be licensed in the State of Utah as a Registered Nurse in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended, and have at least one year of paid experience working wiht individuals with severe physical disabilities at the time of hire.

4 - 2 Assessment Instrument

The Minimum Data Set - Home Care (MDS-HC©) serves as the standard comprehensive assessment instrument.

5 SELF-DIRECTED EMPLOYEE MODEL

A. The self-directed employee model requires the waiver participant to use a Waiver Personal Services Agent as an integral component of the waiver services to assist with managing the employer-related financial responsibilities associated with the self-directed employee model. The Waiver Personal Services Agent is a person or organization that assists the waiver participant and his or her representatives, when appropriate, in performing a number of employer-related tasks, without being considered the common law employer of the service providers. Tasks performed by the Waiver Personal Services Agent include documenting service worker's qualifications, collecting service worker time records, preparing payroll for participants' service workers, and withholding, filing, and depositing federal, state, and local employment taxes.

B. Participant employed service workers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Personal Services Agent for processing. The Waiver Personal Services Agent files a claim for reimbursement to the Medicaid MMIS system, through the Department of Human Services USSDS system, completes the employer-related responsibilities, deducts the established administrative fee, and forwards payment directly to the service worker for the services documented on the time sheet.

6 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

A. The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods are: 1) existing market survey or cost survey of current providers, 2) component cost analysis, 3) comparative analysis, and 4) community price survey.

B. Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or all of the waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.

C. The State Medicaid Agency will maintain records of changes to the maximum allowable rate (MAR) authorized for each waiver covered service to document the rate setting methodology used to establish the MAR.

7 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Home and Community-Based Services Waiver for Individuals with Acquired Brain Injuries.

PHYSICAL DISABILITIES WAIVER CODES/RATES
Effective: July 1, 2004

WAIVER SERVICE	CODE	UNIT OF SERVICE	MAXIMUM ALLOWABLE RATE
Consumer preparation, personal attendant care	S5108	15 minute	$5.08
Local area support coordination liaison	T2041	15 minute	$14.10
Personal attendant care	S5125	15 minute	$3.05
Personal emergency response systems, purchase	S5160	Each	$225.91
Personal emergency response systems, service fee	S5161	Per month	$38.85
Personal emergency response systems, installation & testing	S5162	Each	$50.00

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